Frederick County Health Access Program

An Initiative of the Frederick County Health Care Coalition
In Partnership with the Frederick County Health Department
Providing Connections to Care
Ph. 301-788-8592 FAX 866-430-9751

PATIENT REQUIREMENTS AND RESPONSIBILITIES

The following are requirements for enrollment in the Frederick County Health Access Program (FCHAP). We ask that you follow the guidelines below to demonstrate your willingness to do your part to improve your health.

_____ This is not an insurance program or government entitlement program. Physicians are volunteering to provide health care services for a very small visit fee of $15. You will be required to pay this fee prior to your visit.

_____ You are not eligible for FCHAP services if you have access to health insurance. You will be expected to immediately contact FCHAP if you become enrolled in Medicaid, Medicare, private insurance or any other medical coverage or if you qualify for these programs.

_____ You will need to immediately contact FCHAP if your household income changes or if your address or phone number changes.

_____ All initial appointments with physicians will be made for you by the FCHAP staff. You may schedule follow-up appointments but need to notify FCHAP staff prior to the appointments to ensure that FCHAP benefits will be available.

_____ Please keep all scheduled appointments. If you miss 2 appointments without notifying the doctor's office and FCHAP at least 24 hours before the appointment, you will be dropped from the program.

_____ Referrals to a specialist will be made based on your primary care physician's recommendation and arranged by the FCHAP coordinator. Call FCHAP or your primary care physician if you need to be seen anywhere else for treatment.

_____ You agree to follow your treatment plan (for example: get prescribed medications and take as directed).

_____ Present your FCHAP ID care each time you see a FCHAP doctor or get ordered tests at an FMH site.

_____ FCHAP reserves the right to revoke your enrollment for any reports of discourtesy, abusive language or threats.

_____ If you have any legal action pending regarding your medical needs you must notify FCHAP immediately. Failure to disclose this information will result in immediate dismissal and you will be financially responsible for all medical care received during the time you have pending legal action.

_____ Some physician visits and procedures ordered by your physician may not be covered by FCHAP. You will be financially responsible for treatments, procedures, tests or services not available through FCHAP. FCHAP staff will help you with applying for the FMH financial assistance program.

_____ FCHAP will help you obtain medications ordered by your physician but the total cost of these medications will NOT be covered by the program. If you need prescription assistance, contact the Program Coordinator BEFORE getting prescriptions filled. The program cannot reimburse prescription costs and does not cover the cost of $4 generic medications.

_____The enrollment period for FCHAP is 6 months. To remain in the program, applicants must complete a reenrollment process every 6 months.

_____ Acceptance into the Frederick County Health Access Program does not guarantee assistance with every health care need or request. Services are limited by the availability of participating primary care providers and specialists. Continuation of this program is dependent upon grant funding and donations so the assistance available may change at any time.

I have read the above and agree to comply with all requirements for participation. I further agree to provide truthful and accurate information regarding my financial, health, and employment status. I understand if I withhold information or provide false information I will immediately be disqualified from participation in this program and may be required to pay for any assistance provided by the program. My initials above indicate I understand the information in this document and have been given a copy for my records.

_____ _____

Signature of applicant Date

_____ _____

FCHAP Coordinator/Case Manager Date